Working DRAFT
September 13, 2006

San Diegans for Healthcare Coverage

…a unique collaborative focused on improving the health of our communities

San Diego Healthcare Connection

Demonstration Pilot Project
Concept Overview and Summary

September 13 2006

Contact:
Michelle Doty Cabrera, District Representative
619-409-7690
michelle.cabrera@sen.ca.gov

Jan C. Spencley, Director, San Diegans for Healthcare Coverage
619-543-0974
jan-mithras@cox.net

SB103: San Diego Healthcare Connection
OVERVIEW

Working DRAFT
September 13, 2006

San Diego Healthcare Connection (SDHC)

- ☑ SDHC was developed through a collaborative consensus process between business, labor, consumer, health provider, health plan and community participation over a period of two years.
- ☑ SDHC provides coverage through the workplace with all segments contributing to funding (employee, employer, government), establishes a basic, essential benefits package, a premium assistance program that integrates job-based coverage with publicly funded healthcare coverage for lower-income workers, and individual premium contributions, co-payments and deductibles based upon family income up to 300% of the poverty level.
- ☑ The SDHC premium assistance program is transitional and allows newly providing employers to begin to offer coverage at a more affordable employer contribution level that escalates over a period of five years (30% to 60%); the program is based upon a successful model demonstrated by Sharp FOCUS program which achieved more than 80% retention of coverage after premium assistance terminated.
- ☑ SDHC provides for participation by employers not offering coverage to employees, as well as those currently offering coverage (with crowd-out protections), to target uninsured workers in all settings and to capture all potential sources of funding for coverage.
- ☑ SDHC maximizes efficiency by using existing administrative structures and health plans to provide coverage with specific benefit package(s) to ensure access and improved health outcomes.
- ☑ The SDHC demonstration will pilot a coverage program *targeted* to an estimated 284 ,000 San Diego uninsured in families with *full-time workers* and 224,000 under 300% FPL:
  - Approximately 154,000 adult full-time workers under 300% FPL eligible for the premium assistance program and 53,000 without premium assistance.
  - More than 54,600 uninsured dependent children with 50,000 children under 300% FPL for enrollment in current and future public coverage programs; if not eligible and foundation funding available to cover employer share, enrollment through SDHC program.
  - If foundation funding becomes available to provide support with employer share of premium, approximately 21,000 dependent non-working spouses of eligible full-time workers under 300% FPL through enrollment in the premium assistance program.

SDHC Demonstration Objectives

- ☑ To achieve employer and employee enrollment up to funding available to the SDHC pilot; for example, with a $15 million annual State investment, achieve *average annual enrollment* of more than 15,000 workers --an average of 182,000 months of coverage per year, and generate:
  - More than $140 million in new employer and employee funding over the five year period.
  - Approximately $67.5 million in Federal funds over the five year period.
- ☑ Achieve average annual employer retention rates in the SDHC program of 80% or more.
- ☑ Estimate savings to existing public programs by enrollment in SDHC demonstration of uninsured individuals who would have become eligible for public programs as a result of changes in their medical or other linkage status during enrollment (e.g., pregnancy). Estimate reductions in uncompensated care and improved health outcomes through enrollment of currently uninsured in SDHC demonstration coverage program.
- ☑ Use findings to estimate overall cost reductions for business, government and individuals.

Working DRAFT
September 13, 2006

Supporting Arguments

- ☑ A State investment of $15 million per year in the demonstration pilot could leverage an average of more than $55 million in coverage per year and $275 million over five years, generating a total of no less than $4.60 in funding for coverage for every State dollar invested by the fifth year of the program.
- ☑ San Diego has achieved trade-offs and reached consensus on coverage across diverse constituencies in designing the pilot; a similar consensus has not yet been achieved at the State or Federal levels.
- ☑ An investment in a local pilot provides an opportunity to test alternatives which should result in reduced costs to public programs, improved health outcomes, reduction in uncompensated care and a reduction in long-term public costs. Historically, State DHS has resisted local pilot programs; however, California's size serves as a barrier to pursuing demonstration pilots statewide.
- ☑ By eliminating the current "*either-or*" private or public coverage scenario, the SDHC program can demonstrate an alternative that improves access to healthcare coverage for both business and lower income workers.
- ☑ SDHC is a voluntary program; currently, 48 states (and San Francisco) have introduced or passed legislation regarding mandating employer-sponsored coverage and others, including California, have or are pursuing, individual coverage mandates. The SDHC program provides a viable and affordable alternative to these initiatives.
- ☑ SDHC demonstration pilot offers a potential *win-win* solution to reduce overall costs and to maintain and expand healthcare coverage for business, workers and government in the future.

San Diego Healthcare Connection

Demonstration Concept Summary

San Diegans for Healthcare Coverage (SDHCC) is proposing an innovative pilot demonstration project for expanding healthcare coverage to uninsured low-income workers and their families through job-based coverage and the integration of private and public funding. SDHCC is a collaborative including business, labor, consumer, healthcare, health plan, community and local government.

Situation – Background

Healthcare coverage in California, and the nation, is once again a growing concern; reversing the trends of the 1990's, the ranks of the uninsured are growing at an alarming rate. The growth can be attributed to the economy, federal and state budget shortfalls, escalating premium costs and rapidly increasing workers compensation and other business costs. Between 2001 and 2003, employer-sponsored coverage decreased by close to 6% -- going from 63% to 59% of San Diego non-elderly and there is every indication that this trend is continuing. Small businesses are especially hard hit by the economy and rising costs; the business community is looking for solutions and assistance with providing healthcare coverage.

Increasingly, low-income working adults without eligible children are finding coverage inaccessible or unaffordable. Low to modest income working adults have fewer and fewer options to care for their health resulting in poor health outcomes and increased uncompensated care, premiums and public program expenses.

San Diego is proposing to pilot coverage expansion through job-based coverage that, if successful, will improve the feasibility of expanding coverage on a statewide basis during better economic conditions.

San Diego Initiatives

For several years, the San Diego Improving Access to Healthcare Coverage (IAH) Project worked to develop and implement short and long-term strategies to expand access to healthcare through both private and public healthcare coverage. In 2001, the IAH formed the non-profit San Diegans for Healthcare Coverage (SDHCC) to continue and focus efforts to pursue coverage expansion. SDHCC is a collaborative including local government, business, labor, consumer, healthcare and other community representatives (*Attachment 1*).

The SDHCC goal is to implement a San Diego demonstration project to integrate private and public funding sources for low and modest income workers and their families. The demonstration project would use existing coverage vehicles to expand coverage through the workplace, supplemented by public program funding.

In the interim, the SDHCC pursued and implemented the Business Healthcare Connection (BHC); a not-for-profit subsidiary formed in partnership with the business community and funded by The California Endowment. The BHC provides outreach, education, tools and enrollment assistance to employers and their employees to make them aware of their health coverage choices in both the private and public sectors. As a part of this effort, the BHC has developed partnerships with local brokers, outreach providers, business associations and labor.

The San Diego coverage proposal was further defined through a series of Business and Labor Roundtable sessions held during 2004 and 2005. Each Roundtable session included participation by a panel representing business, labor, consumer, healthcare, and health plan leaders. The Roundtable audience participated in the discussion using an Audience Response System (ARS). Between sessions, focus groups and on-line surveys were used to secure input from the various constituencies to finalize

Working DRAFT
September 13, 2006

decisions and to inform and help shape subsequent sessions. There were significant trade-offs and consensus reached through the Roundtable series related to key elements for expanding coverage including general principles, target populations, essential basic benefits, co-payment and deductible levels by income group, premium shares and general plan design.

San Diego Healthcare Connection Concept (Summary)

San Diego proposes to partner with the State and Federal governments to develop and implement a pilot for an integrated private-public healthcare program in San Diego. The ***San Diego Healthcare Connection*** program would expand and improve access to healthcare coverage for low-income workers and their families, as well as businesses. The San Diego program proposes the following elements for its pilot healthcare coverage program:

☑ ***Enrollees:*** Phase 1 would include uninsured employees not currently eligible for public programs working more than 20 hours per week are through a job-based premium assistance program (*Attachment 2*); employees working more than 20 hours a week would be eligible in Phase 1 of the program. Phase 2 of the program will address feasibility and coverage of part time and employees with employers, as well as unemployed spouses of workers.

☑ ***Coverage Vehicles***. Health plans currently offering commercial coverage and participating or partnering with health plans providing Healthy Families coverage in San Diego County would provide the healthcare coverage (*criteria under discussion*).

☑ ***Benefit Plans:***

- A basic essential benefits plan (***Attachment 3***) ("*Basic Plan")* would serve as the base against which the premium assistance program would be applied.
- Co-payment and deductibles for the Basic Plan based upon family income category (federal poverty level) at the time of enrollment (***Attachment 4***); deductibles are applicable after a specified level of eligible expense has been incurred.
- Well-child care, immunizations and recommended screening and periodic examinations are exempt from co-payments and deductibles.
- Employers and individuals may select a *broader* benefit package but will be responsible for the difference in cost between the Basic Plan and any broader benefit package selected.
- Healthy behavior incentives will be used to encourage healthy lifestyles and compliance with physician recommendations (e.g., disease management education for chronic conditions).

☑ ***Premium.*** Premium funding for the pilot program is proposed to be obtained through a combination of employer and employee contributions and State and Federal funding:

- A composite or modified composite premium structure to simplify program administration.
- Employers *currently not offering coverage* will be eligible to participate in the pilot program with a minimum contribution equal to 30% of the employee-only premium for the first two years, increasing to 40% for the third year, 50% for the fourth year and 60% for each subsequent year; employers may choose to participate at higher contribution levels.
- Employers *currently offering coverage* will be eligible to participate through participating SDHC health plans, and cover their uninsured employees by contributing at their current contribution levels, but not less than 60% of employee-only premium.
- Self employed individuals and other single-employee firms will be eligible to participate through the program at SDHC premium rates and will contribute the applicable employer and employee share of premium.
- Employee share of premium will be at one of several fixed levels based upon family income category (Benefit Group) and will be equal to approximately 2.0% of gross family income.

Working DRAFT
September 13, 2006

- It is assumed that Federal matching funds will be obtained to cover 50% of the premium assistance and program administration.
- Private sources of funding (foundations) will be pursued to provide planning, some of the local start-up costs, outreach and enrollment, and program evaluation. In addition, SDHCC will pursue foundation funding for employer share of premium for eligible dependents (spouses and children) not eligible for other coverage programs.

☑ ***State Administration***. Use of existing State contracts with health plans may eliminate the need for new or duplicative administrative structures; some modifications to existing health plan agreements and processes would be required. It is assumed that a third-party administrator would pay health plans for employer-sponsored enrollees enrolled in the SDHC program.

☑ ***Local Administration***. SDHCC will be designated in State legislation and will have a contract with the State of California as the local administrative arm of MRMIB for the San Diego demonstration pilot program. Building on the success of the SDHCC subsidiary, the Business Healthcare Connection (BHC) and its business and community partnerships, SDHCC would provide coordination (with local plans and brokers), marketing, outreach and unbiased education and assistance to employers and employees, as well as enrollment assistance and support. The enrollment process should be straightforward and simple with minimal verification requirements (with audit processes) and include a web-based enrollment and disenrollment process.

☑ ***Legislation.*** Legislation and a federal Health Insurance and Financing Administration (HIFA) waiver would be required to establish and implement the demonstration project

Government Funding

The source of funding for the State share would depend upon the State's preferences and negotiations with the Federal government. There are examples from other State programs that use some combination of private, employer, and government funds (*three-share programs)*; it is anticipated that the SDHC program would be funded similarly.

Table 1

Example: Monthly Per-Enrollee Cost Estimates

Category	Melded (Newly Providing and Currently Providing Average)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Average
Premium	$ 274	$ 287	$ 301	$ 316	$ 331	$ 302
Subscriber	$ 28	$ 30	$ 31	$ 33	$ 35	$ 31
Employer	$ 95	$ 99	$ 120	$ 140	$ 158	$ 122
Subtotal	$ 123	$ 129	$ 152	$ 173	$ 193	$ 154
State Match	$ 76	$ 79	$ 75	$ 72	$ 69	$ 74
Federal	$ 76	$ 79	$ 75	$ 72	$ 69	$ 74
Total Govt	$ 151	$ 158	$ 149	$ 143	$ 138	$ 148

Table 1 summarizes estimated monthly premium and sources of funding per enrollee for the SDHC program over 5 years for the estimated enrolled population assuming 5% annual inflation, 85% enrollment from firms newly providing coverage and average contributions across family income categories (benefit groups). This scenario includes all optional benefits which are currently under review and discussion regarding the cost – benefit for the target population.

Working DRAFT
September 13, 2006

A less costly mechanism to implement coverage expansion by integrating employer-sponsored coverage with public funding; the example in *Table 2* compares a per enrollee per month expenses for the first-year SDHC program to traditional employer coverage assuming a standard 75% employer share of premium. As demonstrated in the chart, the SDHC program offers a more realistic mechanism for employers to begin offering coverage to low-wage workers and for employees to accept coverage, as well as a less-costly model for the State to expand coverage.

Table 2

Example Per-Member-Per-Month (PMPM) Comparison

SDHC to Traditional Employer Sponsored Coverage

Example Comparison: Year 1 Adult			
Category	Traditional ESI (75-25%)	SDHC	Difference (Trad ESI to SDHC)
Premium	$ 274	$ 274	$ -
Subscriber	$ 69	$ 28	$ (40)
Employer	$ 206	$ 95	$ (111)
Subtotal	$ 274	$ 123	$ (151)
State	$ -	$ 76	$ 76
Federal	$ -	$ 76	$ 76
Government	$ -	$ 151	$ 151

Capture and leverage available funding contributions from employer coverage offered but currently not accepted by employees due to affordability. In 2003, approximately 17% of adult uninsured workers are offered but do not accept employer coverage, primarily due to affordability (e.g., inability to pay their share of premium); it is assumed this figure has increased with the shift of more cost to the employee over the past three years.

Reduced use of State health programs by covering individuals who, over time, would be linked to Medi-Cal and other public programs by virtue of their medical condition; this includes pregnancy, neonatal care, End State Renal Disease (ESRD), Transplantation, Breast Cancer and conditions that result in incapacity or short term disability.

Reduction in uncompensated care costs to the safety net, including hospitals, physicians, clinics and other health providers; while difficult to quantify, covering the uninsured should help to stabilize the safety net, reduce government subsidies and ultimately reduce insurance premiums.

Improved health outcomes related to the previously uninsured, especially as they relate to chronic disease populations; ultimately, this should result in both reduced social and public costs.

Why State and Federal Governments Should Support the San Diego Project

- ☑ **Meets a Need.** The Federal government is seeking innovative coverage expansion programs, as well as methods to integrate private and public coverage. Employers and employees are seeking assistance with health coverage. The San Diego Demonstration proposal is a viable model for achieving these objectives and testing program features at the local level;

Working DRAFT
September 13, 2006

- ☑ **Represents Consensus Across Diverse Constituencies.** Through its local collaborative and the business and labor roundtable series, San Diego has been able to achieve trade-offs and a consensus on a concept and model while there are still no agreements across constituencies at the State and Federal levels.
- ☑ **Reduce Future Expansion Costs.** Tests and demonstrates a model that would significantly reduce the Federal and State cost for expanding coverage in the future.
- ☑ **Win-Win Replicable Model.** Demonstrate a win-win, replicable model for integrating private and public coverage that will help the business community, government and low-income working families while not only not *crowding out* current private coverage, but expanding private coverage.
- ☑ **Access Available Coverage-Funding.** Demonstrate a cost-efficient model that takes advantage of available employer contributions for low-income workers and family members who cannot afford to accept coverage offered.

Working DRAFT
September 13, 2006

Attachment 3
Service -- Benefit Summary
Covered Services

Service Category	Benefit Description
Primary Care: Services provided by primary care provider (PCP), including office visits, supplies and administered drugs; preventive, wellness exams and education.	Must select a PCP from a specific group/clinic in plan network. No coverage outside of designated group. May switch PCP through plan (HMO).
Specialty Care: Services provided by a specialist, including office visits, supplies and administered drugs and outpatient and inpatient consultations, maternity, surgery and other procedures.	On referral by PCP for initial consultation to group panel; prior approval for ongoing care; No coverage outside designated panel. (HMO)
Diagnostic: Laboratory, Radiology, Cardiac and other diagnostic tests and procedures ordered by a physician. Includes routine screening exams (mammograms, pap smears, colon exams)	Routine tests and screening ordered by PCP. Some expensive tests prior approved by plan. (HMO)
Hospital: In-patient hospital medical, surgical and maternity services or maternity delivery services and newborn care. All hospitalizations are approved and reviewed by plan.	Medically necessary hospitalization in hospital designated by primary physician and plan. (HMO)
Pharmacy: Prescription drugs ordered by your physician necessary to treat a medical condition.	Covers drugs through tiered system of generic, preferred and non-preferred only.
Rehabilitation Services: Outpatient Therapy, Home Health Care or Skilled Nursing Facility (SNF) services and equipment necessary to improve functioning following an illness or injury.	Medically necessary outpatient therapy and home health care; short term rental/ purchase of most required medical equipment at 80%; up to 30 days in a Skilled Nursing Facility for rehabilitation. All with plan approval.
Transplantation – Investigational: Organ transplant services and treatments still under investigation (e.g., drugs, devices, treatments)	Organ transplants covered at designated facilities for cases approved by health plan according to transplant criteria. Investigational services, drugs and devices not covered.
Mental Health: Outpatient and inpatient mental health and chemical dependency services.*	Up to 20 visits per year for therapy; up to 20 days per year in hospital for mental health or chemical dependency treatment with prior plan approval.
Quality of Life: Services are not to treat a current medical condition but which may improve quality of life (e.g., Fertility treatments, Weight reduction, etc.)	Covers such things as weight-reduction program/procedures at 50%, infertility treatments at 50% subject to criteria.
Dental: Services provided by a dental health professional to care for teeth**	X-rays, Cleanings each six months at no cost. $50 deductible ($150 per family), then 80% for basic dental services (filling cavities, removal of teeth, oral surgery). 50% for major dental services (crowns/bridges, repairs) Annual max $2,000.
Vision: Eye examinations (including acuity, pressures, etc.), glasses and contact lenses**.	Routine eye examination every two years; $100 for glasses or lenses every two years.

Disease Management Education and Program with defined participation criteria and minimum service requirements to be a required benefit

Not Covered: Complementary Services (Acupuncture, Chiropractic), Experimental Services, non-emergency out of network or unauthorized services.

*Under review and further definition between mental health and chemical dependency services

**Under analysis and review as optional benefits

Working DRAFT
September 13, 2006

Attachment 4
San Diego Healthcare Connection

Co-payment Levels

Benefit Group	Visits	Rx Drugs - Generic	Rx Drugs - Preferred	Rx Non-Preferred	Expnsve Tests	ER/Hospital
A (0-199% FPL)	$ 5.00	$ 2.50	$ 5.00	$ 7.50	$ 15.00	$ 25.00
B (200-299% FPL)	$ 10.00	$ 5.00	$ 10.00	$ 15.00	$ 30.00	$ 50.00
C (300-399% FPL)	$ 10.00	$ 5.00	$ 10.00	$ 15.00	$ 30.00	$ 50.00
D (400% + FPL)	$ 20.00	$ 10.00	$ 20.00	$ 30.00	$ 75.00	$ 100.00

Co-payments limited to maximum equal to approximately to 5% annual gross income by Benefit Group.

Deductibles*

Benefit Group	Indiv	Family
A (0-199% FPL)	$ -	$ -
B (200-299% FPL)	$ -	$ -
C (300-399% FPL)	$ 250	$ 500
D (400% + FPL)	$ 500	$ 1,000

*Well-child care, recommended screenings, exams and immunizations exempted from deductible. Deductible to apply after specified level of covered expense (e.g., $1,000) per person per year.